CODERS' SPECIALTY GUIDE

Urology & Nephrology

2027

AAPC

Your essential illustrated coding guide for urology & nephrology, including CPT®, HCPCS Level II, tips, CPT® to ICD-10-CM Cross References, NCCI edits, and RVU information

Contents

General Surgical Procedures

+10004

Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)

Clinical Responsibility

With the patient properly prepared and anesthetized (typically with local anesthesia) and following FNA of an initial lesion, the provider inserts a needle, such as an 18- to 25-gauge needle with an attached syringe, into an additional suspicious lesion or area of tissue and withdraws cells, tissue, or fluid for laboratory analysis. The provider may make several passes to obtain an adequate specimen. The provider then sends the aspirate to the pathology lab for analysis.

Coding Tips

For FNA of an initial lesion using imaging guidance, see 10005 (ultrasound), 10007 (fluoroscopy), 10009 (CT), and 10011 (MRI) and +10006, +10008, +10010 and +10012 for each additional lesion respectively.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $36.92, Non Facility Fee: $53.37; Non-QP Conversion Factor $33.4009, Facility Fee: $36.74, Non Facility Fee: $53.11
RVU (Facility): Work 0.78, PE 0.19, Mal 0.13, Total 1.10
RVU (Non-Facility): Work 0.78, PE 0.68, Mal 0.13, Total 1.59
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 3

Modifier Allowances

52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, GA, GC, GZ, LT, PD, Q6, QJ, RT, SC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[1], 0216T[1], 10012[1], 10035[1], 19281[1], 19283[1], 19285[1], 19287[1], 36000[1], 36410[1], 36591[0], 36592[0], 61650[1], 62324[1], 62325[1], 62326[1], 62327[1], 64415[1], 64416[1], 64417[1], 64450[1], 64454[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64493[1], 76000[1], 76380[1], 76942[1], 76998[1], 77001[1], 77002[1], 77012[1], 77021[1], 96360[1], 96365[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0]

ICD-10-CM Cross References

C00.3, C01, C02.9, C04.1, C06.9, C07, C08.0, C12, C13.9, C15.9, C22.0-C22.4, C22.7, C22.8, C32.1, C32.8, C34.30-C34.32, C43.20-C43.22, C43.30-C43.39, C43.51-C43.59, C43.60-C43.62, C46.0, C50.011-C50.019, C50.111-C50.119, C50.211-C50.219, C50.411-C50.419, C50.811-C50.819, C50.911-C50.919, C51.9, C76.0, C76.1, C77.0, C77.3, C79.2, C79.81, C79.89, C79.9, C82.50, C82.51, C82.55, C82.59, C83.31-C83.35, C84.90, C84.91, C84.95, C84.99, C84.9A, C84.A0, C84.A1, C84.A5, C84.A9, C84.AA, C84.Z0, C84.Z1, C84.Z5, C84.Z9, C84.ZA, C85.10, C85.11, C85.15, C85.19, C85.1A, C85.20, C85.21, C85.25, C85.29, C85.2A, C85.80, C85.81, C85.85, C85.89, C85.8A, C85.90, C85.91, C85.95, C85.99, C85.9A, C86.00, C86.01, C86.40, C86.41, C88.80, C88.81, C94.40-C94.42, C94.6, D03.20-D03.22, D03.30, D03.39, D03.51-D03.59, D03.60-D03.62, D05.00-D05.02, D05.10-D05.12, D05.80-D05.82, D05.90-D05.92, D11.0-D11.9, D17.0, D17.1, D17.20-D17.24, D17.30, D17.39, D17.72, D17.79, D17.9, D19.7, D21.0, D22.5, D22.70-D22.72, D23.5, D23.70-D23.72, D36.0, D36.7, D37.030-D37.039, D44.0-D44.2, D44.9, D47.1, D47.2, D47.9, D47.Z9, D48.0-D48.2, D48.60-D48.62, D48.7, D48.9, D49.0-D49.7, D49.9, D64.9, D75.9, D78.01, D78.02, D78.21, D78.22, D89.2, E01.0-E01.2, E03.4, E03.9, E04.0-E04.9, E06.0, E07.89, E07.9, E35, E36.01, E36.02, E65, E78.71, E89.820-E89.823, G97.31, G97.32, G97.51, G97.52, G97.63, G97.64, H66.10-H66.13, H69.80-H69.83, H93.8X1-H93.8X3, H93.8X9, H94.80-H94.83, H95.21, H95.22, H95.41, H95.42, H95.53, H95.54, I42.0-I42.5, I42.8, I42.9, I70.235, I70.245, I70.335, I70.345, I70.435, I70.445, I70.535, I70.545, I70.635, I70.645, I70.735, I70.745, I82.91, I88.1-I88.9, I89.8, I97.410-I97.418, I97.42, I97.610-I97.618, I97.622, I97.640-I97.648, J95.61, J95.62, J95.830, J95.831, J95.862, J95.863, J98.4, K11.20-K11.23, K11.3-K11.6, K11.9, K91.61, K91.62, K91.840, K91.841, K91.870-K91.873, L02.31, L02.415, L02.416, L02.419, L02.91, L03.115, L03.116, L03.119, L03.125, L03.126, L03.129, L03.317, L03.327, L03.90, L03.91, L57.0, L76.01, L76.02, L76.21, L76.22, L76.31-L76.34, L97.501-L97.504, L97.509, L97.511-L97.514, L97.519, L97.521-L97.524, L97.529, L98.3, L98.7, M54.2, M70.20-M70.22, M71.30, M77.10-M77.12, M79.4, M81.0, M96.810, M96.811, M96.830, M96.831, M96.840-M96.843, N60.01-N60.09, N60.11-N60.19, N61.0, N62, N63.0, N63.10-N63.15, N63.20-N63.25, N63.31, N63.32, N63.41, N63.42, N64.1, N64.4, N99.61, N99.62, N99.820, N99.821, N99.840-N99.843, Q18.0-Q18.9, Q87.2, Q87.3, Q87.5, Q87.81, Q87.89, Q89.2, R13.0, R13.10, R18.8, R19.02, R20.8, R20.9, R22.0-R22.2, R22.30-R22.33, R22.40-R22.43, R22.9, R29.4, R59.0-R59.9, R68.89, R69, R90.0, R92.1, R92.8, R99, S90.421D, S90.422D, S90.423D, S90.424D, S90.425D, S90.426D, S90.521D, S90.522D, S90.529D, S90.821D, S90.822D, S90.829D, S90.869A, Z00.6, Z12.89, Z85.21, Z85.3, Z85.6, Z86.79

10005

Fine needle aspiration biopsy, including ultrasound guidance; first lesion

Clinical Responsibility

With the patient properly prepared and anesthetized (typically with local anesthesia), the provider inserts a needle, such as an 18- to 25-gauge needle with an attached syringe, under ultrasound imaging guidance into a suspicious lesion or area of tissue and withdraws cells, tissue, or fluid for laboratory analysis. The provider may make several passes to obtain an adequate specimen. The provider then sends the aspirate to the pathology lab for analysis.

Coding Tips

Report +10006 for each additional lesion in addition to the primary code 10005.

MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, SA, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[1], 10060[1], 11055[1], 11056[1], 11057[1], 11406[1], 11424[1], 11426[1], 11440[1], 11444[1], 11446[1], 11450[1], 11451[1], 11463[1], 11470[1], 11471[1], 11604[1], 11606[1], 11623[1], 11624[1], 11626[1], 11643[1], 11644[1], 11646[1], 11719[1], 11720[1], 11721[1], 11730[1], 11740[1], 11750[1], 11760[1], 11765[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12020[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 20500[1], 29580[1], 29581[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 51701[1], 51702[1], 51703[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[0], 64454[1], 64461[0], 64462[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64473[0], 64474[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 69990[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97597[1], 97598[1], 97602[1], 97605[1], 97606[1], 97607[1], 97608[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[0], 99496[0], G0127[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

10180

Incision and drainage, complex, postoperative wound infection

Clinical Responsibility

The provider cleans the operative site with an antiseptic and may inject a local anesthetic such as lidocaine. Then, he incises the area of wound infection and drains it of fluid collection. He performs copious irrigation of the abscess cavity with something like normal saline solution to adequately remove debris from the wound cavity. This also facilitates subsequent breakup of cavities or compartments of fluid. After complete removal of the pus, he irrigates the wound with an antibiotic solution and packs it with gauze to prevent leakage of cellular fluid from the noninfected tissues surrounding the abscess. Loose packing or gauze allows continued drainage and healing by secondary intention. Alternatively, he may close the wound in layers around a drain. A complicated procedure generally takes longer to perform and requires more extensive expertise and technique on the part of the provider.

Coding Tips

A complicated incision and drainage can involve multiple incisions, drain placements, extensive packing, and a more complicated wound closure. Make sure the documentation supports a complicated incision and drainage.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $176.57, Non Facility Fee: $289.69; Non-QP Conversion Factor $33.4009, Facility Fee: $175.69, Non Facility Fee: $288.25
RVU (Facility): Work 2.24, PE 2.52, Mal 0.5, Total 5.26
RVU (Non-Facility): Work 2.24, PE 5.89, Mal 0.5, Total 8.63
MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[1], 0925T[0], 11720[1], 11721[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12020[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 20500[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 51701[1], 51702[1], 51703[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[0], 64454[1], 64461[0], 64462[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64473[0], 64474[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 69990[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1],

99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[0], 99496[0], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

B95.2, B96.22, E36.8, K68.11, L76.33, L76.34, L76.81, L76.82, O86.00-O86.03, O86.09, O90.2, S31.136D, S31.137D, S31.13AD, S31.146D, S31.146S, S31.147D, S31.147S, S31.14AD, S31.14AS, S31.636A-S31.636S, S31.637D, S31.637S, S31.63AA-S31.63AS, S31.646A, S31.646S, S31.647A, S31.647S, S31.64AA, S31.64AS, S80.851D, S80.852D, S80.859D, S80.861D, S80.862D, S80.869D, S91.151D, S91.152D, S91.153D, S91.154D, S91.155D, S91.156D, S91.159D, S91.211D, S91.212D, S91.213D, S91.214D, S91.215D, S91.216D, S91.219D, T81.40XA-T81.40XS

11000

Debridement of extensive eczematous or infected skin; up to 10% of body surface

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider cleans the area of infected skin. The provider then performs debridement by cutting away the dead tissue using surgical instruments like a scalpel or scissors. The provider performs debridement until he sees healthy bleeding on the skin edges. The provider then controls bleeding, applies an antibiotic, and dresses the wound. Use this code for debridement of up to 10 percent of the body surface.

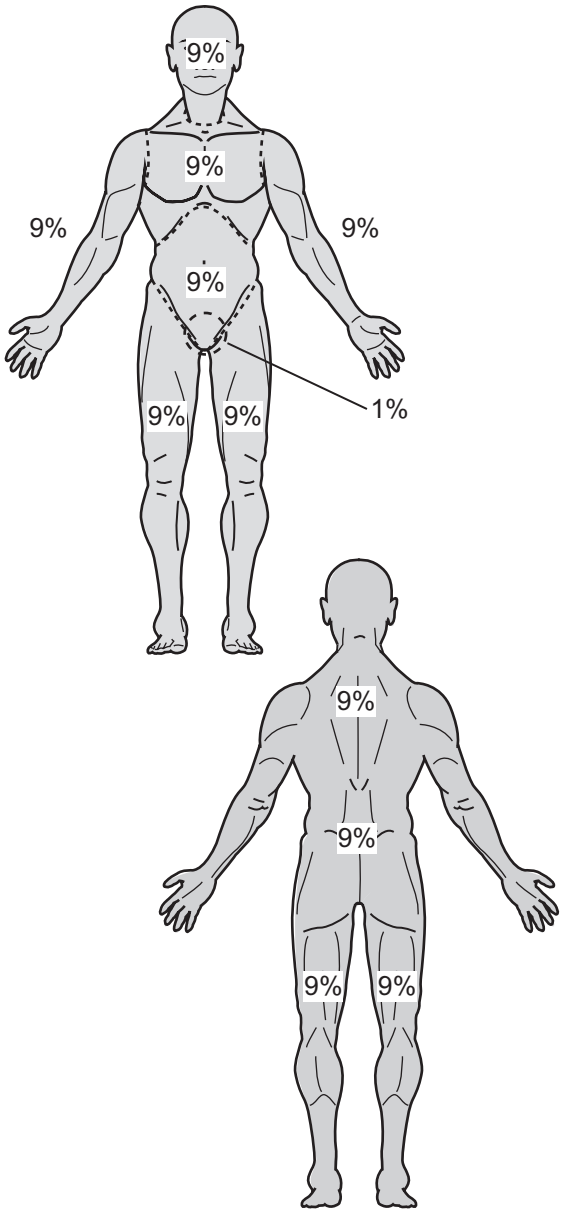
Coding Tips

Use +11001 as an add-on code for each additional 10 percent of the body surface.

This code is for surgical debridement. For removal of devitalized tissue (nonselective debridement) from wound(s), without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion, larval therapy), ... per session, see 97602. Larval therapy refers to maggot therapy.

This code also does not include dermabrasion; for dermabrasion services, see codes 15780 to 15787.

Illustration



11000, +11001

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $24.17, Non Facility Fee: $59.41; Non-QP Conversion Factor $33.4009, Facility Fee: $24.05, Non Facility Fee: $59.12
RVU (Facility): Work 0.59, PE 0.08, Mal 0.05, Total 0.72
RVU (Non-Facility): Work 0.59, PE 1.13, Mal 0.05, Total 1.77
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 51, 52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 99, AQ, AR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

Modifier: 0 = not allowed, 1 = allowed

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0552T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10060[1], 10061[1], 11008[1], 11010[1], 11011[1], 11012[1], 11056[1], 11057[1], 11719[1], 11720[1], 11721[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13102[1], 13122[1], 13133[1], 13153[1], 17110[1], 17250[1], 20552[1], 20553[1], 20560[1], 20561[1], 20600[1], 20604[1], 24300[1], 29000[1], 29010[1], 29015[1], 29035[1], 29040[1], 29044[1], 29046[1], 29049[1], 29055[1], 29058[1], 29065[1], 29075[1], 29085[1], 29086[1], 29105[1], 29125[1], 29126[1], 29130[1], 29131[1], 29200[1], 29240[1], 29260[1], 29280[1], 29305[1], 29325[1], 29345[1], 29355[1], 29358[1], 29365[1], 29405[1], 29425[1], 29435[1], 29440[1], 29445[1], 29450[1], 29505[1], 29515[1], 29520[1], 29530[1], 29540[1], 29550[1], 29580[1], 29581[1], 29584[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[0], 64454[1], 64461[0], 64462[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64473[0], 64474[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 66988[1], 69990[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97607[1], 97608[1], 97610[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0127[1], G0463[1], G0471[1]

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

+11001

Debridement of extensive eczematous or infected skin; each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider uses surgical instruments to debride the infected skin. Add-on code +11001 represents debridement of each additional 10 percent, or portion of that, after the initial 10 percent, which you report using 11000. The provider cleans the area of infected skin. The provider then performs debridement by cutting away the dead tissue using surgical instruments like a scalpel or scissors. The provider does debridement until he sees healthy bleeding on the skin edges. The provider then controls bleeding, applies an antibiotic, and dresses the wound.

Coding Tips

Because +11001 is an add-on code, payers will not reimburse you if you report it without an appropriate primary code (11000) for the initial 10 percent.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $12.76, Non Facility Fee: $27.19; Non-QP Conversion Factor $33.4009, Facility Fee: $12.69, Non Facility Fee: $27.05
RVU (Facility): Work 0.29, PE 0.06, Mal 0.03, Total 0.38
RVU (Non-Facility): Work 0.29, PE 0.49, Mal 0.03, Total 0.81
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 99, AQ, AR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

11008[1], 29000[1], 29010[1], 29015[1], 29035[1], 29040[1], 29044[1], 29046[1], 29049[1], 29055[1], 29058[1], 29065[1], 29075[1], 29085[1], 29086[1], 29105[1], 29125[1], 29126[1], 29130[1], 29131[1], 29200[1], 29240[1], 29260[1], 29280[1], 29305[1], 29325[1], 29345[1], 29355[1], 29358[1], 29365[1], 29405[1], 29425[1], 29435[1], 29440[1], 29445[1], 29450[1], 29505[1], 29515[1], 29520[1], 29530[1], 29540[1], 29550[1], 29580[1], 29581[1], 29584[1], 36591[0], 36592[0], 66988[1], 96523[0]

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

11004

Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum

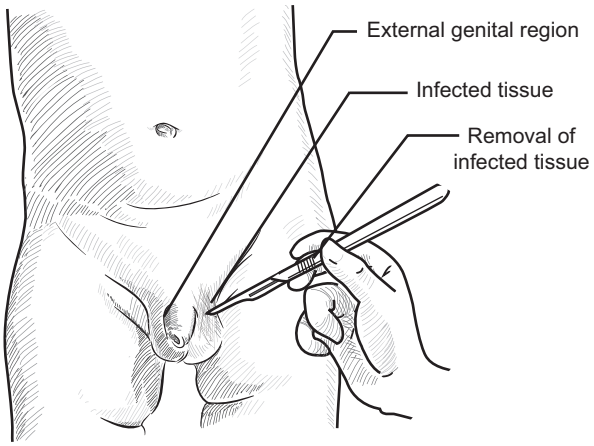
Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider evaluates the extent of the necrotic tissue in the external genitalia and perineum. The provider, by using surgical instruments such as a scalpel or scissors, resects and debrides the infected necrotic skin, subcutaneous tissue, fat, and muscle. The provider tries to preserve as much viable skin and subcutaneous tissue as possible. The provider by doing this allows the remaining healthy tissues to heal properly. The provider then controls bleeding, applies an antibiotic, and packs the open wound with saline soaked gauze.

Coding Tips

See 11005 when the service involves the abdominal wall and see 11006 when the service involves the external genitalia, perineum, and abdominal wall.

Illustration



11004

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $507.20, Non Facility Fee: $507.20; Non-QP Conversion Factor $33.4009, Facility Fee: $504.69, Non Facility Fee: $504.69
RVU (Facility): Work 10.53, PE 2.46, Mal 2.12, Total 15.11
RVU (Non-Facility): Work 10.53, PE 2.46, Mal 2.12, Total 15.11
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 51, 52, 53, 58, 59, 76, 77, 78, 79, 99, AG, AQ, AR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0437T[1], 0552T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10060[1], 10061[1], 11000[1], 11010[1], 11011[1], 11012[1], 11042[1], 11043[1], 11044[1], 11102[1], 11103[1], 11104[1], 11105[1], 11106[1], 11107[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 15769[1], 15777[1], 20552[1], 20553[1], 20560[1], 20561[1], 20700[1], 20701[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 57267[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[0], 64454[1], 64461[0], 64462[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64473[0], 64474[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 66987[1], 66988[1], 69990[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97597[1], 97598[1], 97610[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1]

ICD-10-CM Cross References

A46, A49.01, A49.02, B95.0-B95.4, B95.61, B95.62, B95.7, B96.1-B96.6, B96.89, E08.52, E09.52, E10.52, E11.52, E13.52, I96, K68.11, L76.31-L76.34, L89.139, L89.149, L89.150-L89.154, L89.159, L89.40-L89.45, L98.411-L98.414, L98.419, L98.7, L98.9, M72.6, M79.10, M79.18, N49.1-N49.3, N49.8, N49.9, N50.1, S38.002D, S38.211S, S38.212D, S38.212S, S66.520D, S66.521D, S66.522D, S66.523D, S66.524D, S66.525D, S66.526D, S66.527D, S66.528D, S66.529D, T21.67XD, T21.67XS, T21.77XD, T21.77XS, T75.4XXD, T81.40XA-T81.40XS, Z86.007

11005

Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider evaluates the extent of the necrotic tissue in the abdominal wall. The provider resects and debrides all the infected necrotic skin, subcutaneous tissues, fascia, and muscle by using surgical instruments such as a scalpel, scissors, or other tools. The provider tries to preserve as much viable skin and subcutaneous tissue as possible. The provider, by doing this, allows the remaining healthy tissues to heal properly. The provider then controls bleeding and places multiple drains in all wound sites. He applies antibiotics and packs the open wound with saline soaked gauze. The provider may complete the procedure with or without fascial closure in which he closes the fascia of the abdominal wall.

Coding Tips

See 11004 when the service involves the external genitalia and perineum, and see 11006 when the service involves the external genitalia, perineum and abdominal wall.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $695.85, Non Facility Fee: $695.85; Non-QP Conversion Factor $33.4009, Facility Fee: $692.40, Non Facility Fee: $692.40
RVU (Facility): Work 13.88, PE 3.41, Mal 3.44, Total 20.73
RVU (Non-Facility): Work 13.88, PE 3.41, Mal 3.44, Total 20.73
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 52, 53, 58, 59, 76, 77, 78, 79, 80, 81, 82, AG, AQ, AR, AS, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0437T[1], 0552T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10060[1], 10061[1], 11000[1], 11004[0], 11010[1], 11011[1], 11012[1], 11042[1], 11043[1], 11044[1], 11102[1], 11103[1], 11104[1], 11105[1], 11106[1], 11107[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 15769[1], 15777[1], 20552[1], 20553[1], 20560[1], 20561[1], 20700[1], 20701[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 57267[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[0], 64454[1], 64461[0], 64462[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64473[0], 64474[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 66987[1], 66988[1], 69990[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97597[1], 97598[1], 97610[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1]

ICD-10-CM Cross References

A46, A49.01, A49.02, B95.0-B95.2, B95.4, B95.61, B95.62, B95.7, B96.1-B96.6, B96.89, I96, K68.11, L02.217, L03.31A, L76.31-L76.34, L89.139, L89.149, L98.429, L98.7, L98.9, M72.6, M79.10, M79.18, N49.9, N50.1, S30.11XA, S31.106A-S31.106S, S31.107A-S31.107S, S31.10AA-S31.10AS, S66.520D, S66.521D, S66.522D, S66.523D, S66.524D, S66.525D, S66.526D, S66.527D, S66.528D, S66.529D, T33.3XXD, T75.4XXD, T81.40XA-T81.40XS, Z86.007

11006

Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure

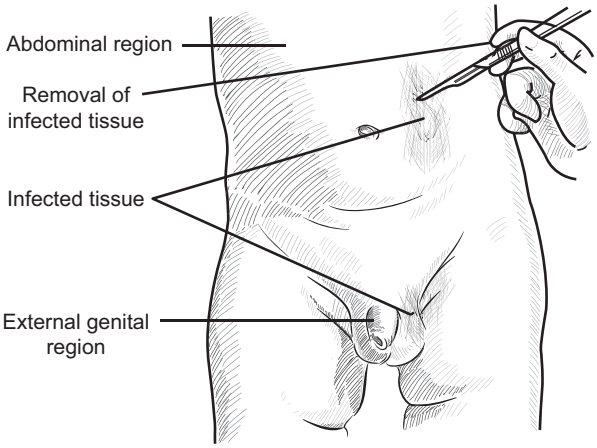
Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider evaluates the extent of the necrotic tissue in the external genitalia, perineum, and abdominal wall. The provider resects and debrides all the infected necrotic skin, subcutaneous tissues, fascia, and muscle by using surgical instruments such as a scalpel, scissors, or other tools. The provider tries to preserve as much viable skin and subcutaneous tissue as possible. The provider, by doing this, allows the remaining healthy tissues to heal properly. The provider then controls bleeding, applies antibiotics, and packs the open wound with saline soaked gauze. The provider may complete the procedure with or without fascial closure in which he closes the fascia of the abdominal wall.

Coding Tips

See 11004 when the service involves external genitalia and perineum and see 11005 when the service involves the abdominal wall with or without fascial closure.

Illustration



11006

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $626.71, Non Facility Fee: $626.71; Non-QP Conversion Factor $33.4009, Facility Fee: $623.59, Non Facility Fee: $623.59
RVU (Facility): Work 12.77, PE 3.09, Mal 2.81, Total 18.67
RVU (Non-Facility): Work 12.77, PE 3.09, Mal 2.81, Total 18.67
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

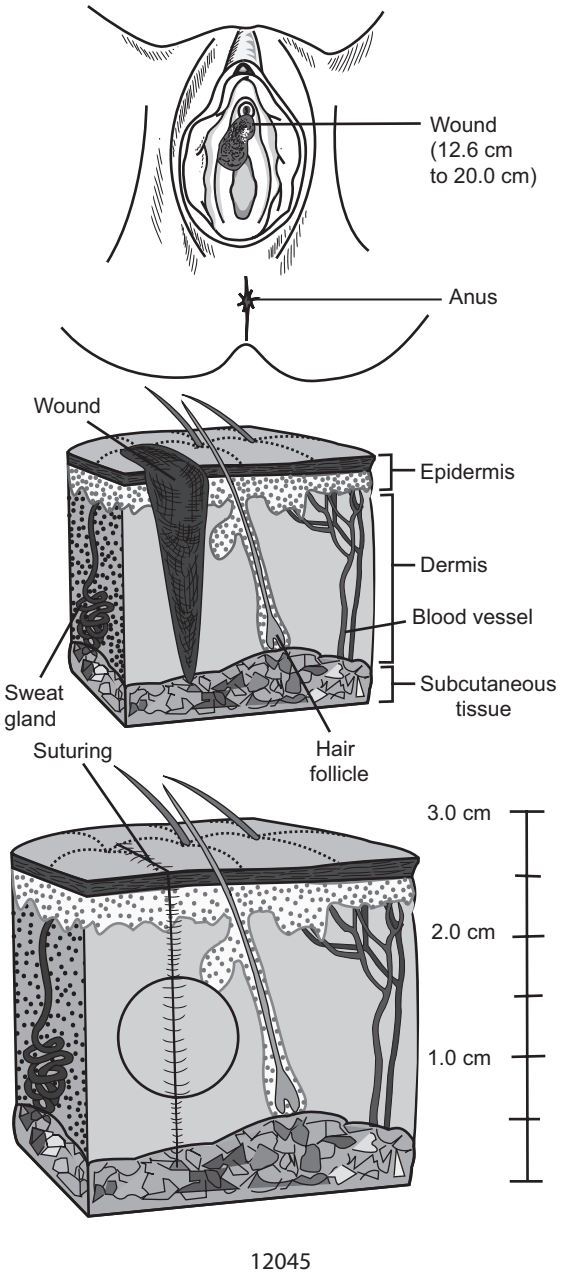
Modifier Allowances

22, 51, 52, 53, 58, 59, 76, 77, 78, 79, AQ, AR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0437T[1], 0552T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10060[1], 10061[1], 11000[1], 11004[0], 11005[0], 11010[1], 11011[1], 11012[1], 11042[1], 11043[1], 11044[1], 11102[1], 11103[1], 11104[1], 11105[1], 11106[1], 11107[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 15769[1], 15777[1], 20552[1], 20553[1], 20560[1], 20561[1], 20700[1], 20701[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 57267[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[0],

Illustration



12045

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $270.22, Non Facility Fee: $455.85; Non-QP Conversion Factor $33.4009, Facility Fee: $268.88, Non Facility Fee: $453.58
RVU (Facility): Work 3.66, PE 3.69, Mal 0.7, Total 8.05
RVU (Non-Facility): Work 3.66, PE 9.22, Mal 0.7, Total 13.58
MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 99, AQ, AR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0569T[1], 0570T[1], 0571T[1], 0572T[1], 0573T[1], 0574T[1], 0580T[1], 0581T[1], 0582T[1], 0655T[1], 0903T[1], 0904T[1], 0905T[1], 11042[1], 11900[1], 11901[1], 12041[0], 12042[0], 12044[0], 12055[1], 15772[1], 15774[1], 20560[1], 20561[1], 20700[1], 20701[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 51701[1], 51702[1], 51703[1], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[1], 64451[1], 64479[0], 64480[0], 64483[0], 64484[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 64625[1], 66987[1], 66988[1], 69990[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97597[1], 97598[1], 97602[1], 97605[1], 97606[1], 97607[1], 97608[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[0], 99496[0], G0168[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

12046

Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm

Clinical Responsibility

Code 12046 includes the intermediate repair of 20.1 to 30 cm wounds of the neck, hands, feet, and/or external genitalia.

After informed consent, the patient is brought to the operating room. Prep and drape of operative site is done in the usual sterile manner and administration of local anesthesia is done. After inspection, the wound is irrigated with normal saline, and proper debridement of the wound is performed. Contaminated single-layered wounds need extensive cleaning to remove particulate matter. Now attention turns to repair of the wound. The wound edges are brought together to form a linear closure. Suture of the inner layer of skin (subcutaneous, dermis, and/or superficial fascia) with absorbable suture is done. External layer is sutured in a linear fashion. Dermabond is applied to the wound.

Note: Report 12046 when the length of the repaired wound ranges from 20.1 cm to 30.0 cm.

Coding Tips

Look for layer descriptions in your physician's chart notes

To properly choose between simple (12001-12021) and intermediate (12031-12057) repair codes, you'll have to rely on your physician's chart notes to make the right selection. To make your job easier, encourage your physician to use specific terms to describe the kind of laceration he or she repaired. Your physician should use terms such as "deeper layers of subcutaneous and superficial (nonmuscle) fascia," "layered closure," or "deep layer suturing" to indicate that he or she performed an intermediate repair.

Document extensive cleaning to up complexity

Make sure your physician documents the extent of the debridement he or she performs. Although intermediate repair usually requires layered closure, you can report appropriate intermediate codes if your physician performs a single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter, according to CPT® guidelines. But your physician may forget to include the cleaning details when recording laceration services. Therefore, you would not know that the repair qualifies for an intermediate repair code and will use a simple repair code instead.

Get to know the multiple-laceration formula

Although reporting a single or intermediate repair may now seem simple, learning the multiple-laceration formula will require you to ratchet up your coding skills. Don't be too quick to blame poor chart notes for all of your coding mistakes. To effectively report laceration services and receive proper reimbursement, you must know how to bill what the chart report contains.

When you combine several repairs, you must base them on repair class, such as simple or intermediate, and the anatomic site. To report several repairs, first tally the number of wounds in the same classification. If the wounds occur in the same anatomic area, such as the knee or stomach, and your physician assigns them the same repair class, such as simple or intermediate, add the repairs together for one total.

Pay attention to CPT® body groupings, because these may change according to a repair's class. For instance, CPT® includes hands, feet, and/or extremities in the same anatomic site for simple repairs (12001-12007). The intermediate repair codes for extremities (12031-12037) exclude hands and feet.

Mind the Modifier 51: To report dissimilar lacerations

CPT® specifies that you should list the more complicated laceration repair as the primary procedure and the less complicated as the secondary procedure when you assign codes for repairs in different classifications or groupings. Be careful when you append 51 to a code. The more complicated procedure will have more RVUs and a higher reimbursement rate than the less complicated procedure. Therefore, reversing the order will lessen your practice's revenue.

For example, suppose your physician treats a patient with three cuts: a 2.8 cm superficial wound on his left shoulder, a 1.1 cm simple laceration on his left ear, and a 3.9 cm wound on his knee that requires layered closure. To code this treatment, follow the earlier classification and grouping recommendations. First look at the two repairs that require simple closure. Although the shoulder and ear wounds fall in the same class, they are not in the same anatomic group. Therefore, you should separately report each repair. For the 2.8 cm simple repair on the shoulder, you should assign 12002. For the 1.1 cm superficial ear laceration, you should use 12011 (*Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less*). You should assign 12032 for the intermediate knee repair.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $314.86, Non Facility Fee: $560.24; Non-QP Conversion Factor $33.4009, Facility Fee: $313.30, Non Facility Fee: $557.46
RVU (Facility): Work 4.19, PE 4.07, Mal 1.12, Total 9.38
RVU (Non-Facility): Work 4.19, PE 11.38, Mal 1.12, Total 16.69
MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T^{0}, 0216T^{0}, 0569T^{1}, 0570T^{1}, 0571T^{1}, 0572T^{1}, 0573T^{1}, 0574T^{1}, 0580T^{1}, 0581T^{1}, 0582T^{1}, 0655T^{1}, 0903T^{1}, 0904T^{1}, 0905T^{1}, 11043^{1}, 11044^{1}, 11900^{1}, 11901^{1}, 12041^{0}, 12042^{0}, 12044^{0}, 12045^{0}, 12056^{1}, 15772^{1}, 15774^{1}, 20560^{1}, 20561^{1}, 20700^{1}, 20701^{1}, 36000^{1}, 36400^{1}, 36405^{1}, 36406^{1}, 36410^{1}, 36420^{1}, 36425^{1}, 36430^{1}, 36440^{1}, 36591^{0}, 36592^{0}, 36600^{1}, 36640^{1}, 43752^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 51721^{1}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{1}, 64451^{1}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 64625^{1}, 66987^{1}, 66988^{1}, 69990^{0}, 92012^{1}, 92014^{1}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{1}, 95829^{1}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 97597^{1}, 97598^{1}, 97602^{1}, 97605^{1}, 97606^{1}, 97607^{1}, 97608^{1}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, 99495^{0}, 99496^{0}, G0168^{1}, G0463^{1}, G0471^{1}, J0670^{1}

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

Procedures/Professional Services

G0102

Prostate cancer screening; digital rectal examination

Clinical Responsibility

The provider performs a prostate cancer screening in which he performs a digital rectal examination to assess the male patient's prostate. To examine the prostate the provider inserts a gloved and lubricated finger into the rectum and checks for hardness, lumps, or any abnormalities. This examination helps detect prostate cancer in its early stages. The provider typically performs this test for the first time at the age of 40 for men at risk of having prostate cancer such as those men with a family history of cancer.

Coding Tips

The Healthcare Common Procedure Coding System, or HCPCS, codes that begin with a G identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

Medicare provides coverage for an annual prostate cancer screening digital rectal examination for men at the age of 50.

Per Medicare guidelines, billing and payment for G0102, Prostate cancer screening; digital rectal examination bundles into the payment for a covered evaluation and management, or E/M service, when the provider renders the two services to a patient on the same day.

BETOS

Y1: Other - Medicare fee schedule

G0103

Prostate cancer screening; prostate specific antigen test (PSA)

Clinical Responsibility

The provider performs a prostate cancer screening in which he detects the prostate specific antigen, or PSA level in the patient's blood. PSA is a protein that increases in the blood of a patient with conditions like prostate cancer. This protein is considered as an indicator for prostate cancer. The provider collects the blood sample through a venipuncture. This test helps to detect prostate cancer in its early stages. A normal level of PSA in blood of men below 50 years of age is less than 2.5, for age 50 to 60 it is less than 3.5, for age 60 to 70 it is less than 4.5 and for age above 70 it is 6.6.

Coding Tips

The Healthcare Common Procedure Coding System, or HCPCS, codes that begin with a G identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes.

Medicare provides coverage for an annual prostate cancer screening, or PSA, test for men at the age of 50.

When the provider performs a prostate specific antigen test to screen for prostate cancer, use G0103, Prostate cancer screening; prostate specific antigen test, PSA. When the provider performs a diagnostic PSA for a patient with symptoms of a prostate abnormality, use 84153, Prostate specific antigen, or PSA; total.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

G0283

Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Clinical Responsibility

The provider uses a wet electrode pad to administer an electric current to one or more areas of the body. This contracts the muscles and improves blood supply to the area. The improvement in blood supply strengthens the muscle and aids in the healing process.

Coding Tips

Use G codes to represent temporary procedures and professional services. Medicare covers G codes for services that replace CPT® codes.

Report this code for Medicare patients and most Medicaid patients. Other payers may require 97014, Application of a modality to one or more areas; electrical stimulation, unattended. Check with your payer for their preference.

To report other therapeutic uses of electric current, see G0281, Electrical stimulation, unattended, to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care, and G0282, Electrical stimulation, unattended, to one or more areas, for wound care other than described in G0281.

If the provider employs electromagnetic therapy, see G0329, Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care, or G0295, Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses.

BETOS

P5E: Ambulatory procedures - other

G0378

Hospital observation service, per hour

Clinical Responsibility

A provider assigns an observation status to a patient who comes to the hospital. The provider monitors the patient to decide whether the patient requires admission to the hospital or can be treated and discharged. This service provides an alternative to inpatient service to the patient, whose clinical status is unstable or at risk of short-term deterioration. This service is reported for each hour of hospital observation service.

Coding Tips

Use one unit of this code for each hour of hospital observation service

Check with the individual payer for their reporting requirements. For instance, the payer may require hospitals to use this code in place of CPT® observation codes.

BETOS

M2A: Hospital visit - initial

G0379

Direct admission of patient for hospital observation care

Clinical Responsibility

This code represents the observation service for a direct patient admission into observation care, such as for a patient who is directly referred to the hospital by a provider in the community. This service provides an alternative to inpatient admission of the patient whose clinical status is unstable or at risk of short-term deterioration. The provider monitors the patient to decide whether the patient requires admission to the hospital or can be discharged.

Coding Tips

Check with the individual payer for their reporting requirements. For instance, the payer may require hospitals to use this code in place of CPT® observation codes.

BETOS

M2A: Hospital visit - initial

G0406

Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth

Clinical Responsibility

Telehealth is a service in which the patient communicates with the healthcare provider through interactive means to support the patient's healthcare when the provider and the patient are physically separated. The service includes discussion of symptoms and diagnoses, monitoring of progress, and recommending changes or new plans according to the patient's health status. The provider performs a problem-focused examination and gives straightforward medical advice of low complexity. In this service, the provider typically will take 15 minutes to communicate with the patient.

Coding Tips

When the provider renders a follow-up inpatient consultation of an intermediate complexity using a telecommunication method and typically spends 25 minutes communicating with the patient, use G0407.

When the provider renders a follow-up inpatient consultation of a complex level using a telecommunication method and spends about 35 minutes communicating with the patient, use G0408.

BETOS

M6: Consultations

G0407

Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth

Clinical Responsibility

Telehealth is a service in which the patient communicates with the healthcare provider through an interactive means to support the patient's healthcare when the provider and the patient are physically separated. The service includes discussion of symptoms and diagnoses, monitoring of progress, and recommending changes or new plans according to the patient's health status. The provider studies the patient's problems in detail and gives medical advice of moderate complexity. In this service, the provider typically will take 25 minutes to communicate with the patient.

Coding Tips

When the provider renders a follow-up inpatient consultation of a limited complexity using a telecommunication method and spends about 15 minutes communicating with the patient, use G0406.

When the provider renders a follow-up inpatient consultation of a complex level using a telecommunication method and spends about 35 minutes communicating with the patient, use G0408.

BETOS

M6: Consultations

G0408

Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth

Clinical Responsibility

Telehealth is a service in which the patient communicates with the healthcare provider through interactive means to support the patient's healthcare when the provider and the patient are physically separated. The service includes the discussion

ICD-10-CM Cross Reference Details

A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae
A00.1 Cholera due to Vibrio cholerae 01, biovar eltor
A00.9 Cholera, unspecified
A01.00 Typhoid fever, unspecified
A01.01 Typhoid meningitis
A01.02 Typhoid fever with heart involvement
A01.03 Typhoid pneumonia
A01.04 Typhoid arthritis
A01.05 Typhoid osteomyelitis
A01.09 Typhoid fever with other complications
A01.1 Paratyphoid fever A
A01.2 Paratyphoid fever B
A01.3 Paratyphoid fever C
A02.0 Salmonella enteritis
A02.1 Salmonella sepsis
A02.20 Localized salmonella infection, unspecified
A02.21 Salmonella meningitis
A02.22 Salmonella pneumonia
A02.23 Salmonella arthritis
A02.24 Salmonella osteomyelitis
A02.25 Salmonella pyelonephritis
A02.8 Other specified salmonella infections
A02.9 Salmonella infection, unspecified
A03.0 Shigellosis due to Shigella dysenteriae
A03.1 Shigellosis due to Shigella flexneri
A03.2 Shigellosis due to Shigella boydii
A03.3 Shigellosis due to Shigella sonnei
A03.8 Other shigellosis
A04.0 Enteropathogenic Escherichia coli infection
A04.1 Enterotoxigenic Escherichia coli infection
A04.2 Enteroinvasive Escherichia coli infection
A04.3 Enterohemorrhagic Escherichia coli infection
A04.4 Other intestinal Escherichia coli infections
A04.5 Campylobacter enteritis
A04.6 Enteritis due to Yersinia enterocolitica
A04.71 Enterocolitis due to Clostridium difficile, recurrent
A04.72 Enterocolitis due to Clostridium difficile, not specified as recurrent
A04.8 Other specified bacterial intestinal infections
A04.9 Bacterial intestinal infection, unspecified
A05.0 Foodborne staphylococcal intoxication
A05.1 Botulism food poisoning
A05.2 Foodborne Clostridium perfringens [Clostridium welchii] intoxication
A05.3 Foodborne Vibrio parahaemolyticus intoxication
A05.5 Foodborne Vibrio vulnificus intoxication
A05.8 Other specified bacterial foodborne intoxications
A05.9 Bacterial foodborne intoxication, unspecified
A06.0 Acute amebic dysentery
A06.1 Chronic intestinal amebiasis
A06.2 Amebic nondysenteric colitis
A06.5 Amebic lung abscess
A06.81 Amebic cystitis
A06.82 Other amebic genitourinary infections
A07.0 Balantidiasis
A07.1 Giardiasis [lambliasis]
A07.2 Cryptosporidiosis
A07.3 Isosporiasis
A07.4 Cyclosporiasis
A07.8 Other specified protozoal intestinal diseases
A07.9 Protozoal intestinal disease, unspecified
A08.0 Rotaviral enteritis
A08.11 Acute gastroenteropathy due to Norwalk agent
A08.19 Acute gastroenteropathy due to other small round viruses
A08.2 Adenoviral enteritis
A08.31 Calicivirus enteritis
A08.32 Astrovirus enteritis
A08.39 Other viral enteritis
A08.4 Viral intestinal infection, unspecified
A08.8 Other specified intestinal infections
A09 Infectious gastroenteritis and colitis, unspecified
A15.0 Tuberculosis of lung
A15.4 Tuberculosis of intrathoracic lymph nodes
A15.5 Tuberculosis of larynx, trachea and bronchus
A15.6 Tuberculous pleurisy
A15.7 Primary respiratory tuberculosis
A15.8 Other respiratory tuberculosis
A15.9 Respiratory tuberculosis unspecified
A17.0 Tuberculous meningitis
A17.1 Meningeal tuberculoma
A17.81 Tuberculoma of brain and spinal cord
A17.82 Tuberculous meningoencephalitis
A17.83 Tuberculous neuritis
A17.89 Other tuberculosis of nervous system
A17.9 Tuberculosis of nervous system, unspecified
A18.01 Tuberculosis of spine
A18.02 Tuberculous arthritis of other joints
A18.03 Tuberculosis of other bones
A18.09 Other musculoskeletal tuberculosis
A18.10 Tuberculosis of genitourinary system, unspecified
A18.11 Tuberculosis of kidney and ureter
A18.12 Tuberculosis of bladder
A18.13 Tuberculosis of other urinary organs
A18.14 Tuberculosis of prostate
A18.15 Tuberculosis of other male genital organs
A18.16 Tuberculosis of cervix
A18.17 Tuberculous female pelvic inflammatory disease
A18.18 Tuberculosis of other female genital organs
A18.2 Tuberculous peripheral lymphadenopathy
A18.31 Tuberculous peritonitis
A18.32 Tuberculous enteritis
A18.39 Retroperitoneal tuberculosis
A18.4 Tuberculosis of skin and subcutaneous tissue
A18.50 Tuberculosis of eye, unspecified
A18.51 Tuberculous episcleritis
A18.52 Tuberculous keratitis
A18.53 Tuberculous chorioretinitis
A18.54 Tuberculous iridocyclitis
A18.59 Other tuberculosis of eye
A18.6 Tuberculosis of (inner) (middle) ear
A18.7 Tuberculosis of adrenal glands
A18.81 Tuberculosis of thyroid gland
A18.82 Tuberculosis of other endocrine glands
A18.83 Tuberculosis of digestive tract organs, not elsewhere classified
A18.84 Tuberculosis of heart
A18.85 Tuberculosis of spleen
A18.89 Tuberculosis of other sites
A19.0 Acute miliary tuberculosis of a single specified site
A19.2 Acute miliary tuberculosis, unspecified
A19.8 Other miliary tuberculosis
A22.7 Anthrax sepsis
A26.7 Erysipelothrix sepsis
A31.0 Pulmonary mycobacterial infection
A31.1 Cutaneous mycobacterial infection
A31.2 Disseminated mycobacterium avium-intracellulare complex (DMAC)
A31.8 Other mycobacterial infections
A32.7 Listerial sepsis
A36.0 Pharyngeal diphtheria
A36.1 Nasopharyngeal diphtheria
A36.2 Laryngeal diphtheria
A36.84 Diphtheritic tubulo-interstitial nephropathy
A36.85 Diphtheritic cystitis
A36.89 Other diphtheritic complications
A38.8 Scarlet fever with other complications
A40.0 Sepsis due to streptococcus, group A

A40.1 Sepsis due to streptococcus, group B
A40.3 Sepsis due to Streptococcus pneumoniae
A40.8 Other streptococcal sepsis
A40.9 Streptococcal sepsis, unspecified
A41.01 Sepsis due to Methicillin susceptible Staphylococcus aureus
A41.02 Sepsis due to Methicillin resistant Staphylococcus aureus
A41.1 Sepsis due to other specified staphylococcus
A41.2 Sepsis due to unspecified staphylococcus
A41.3 Sepsis due to Hemophilus influenzae
A41.4 Sepsis due to anaerobes
A41.50 Gram-negative sepsis, unspecified
A41.51 Sepsis due to Escherichia coli [E. coli]
A41.52 Sepsis due to Pseudomonas
A41.53 Sepsis due to Serratia
A41.54 Sepsis due to Acinetobacter baumannii
A41.59 Other Gram-negative sepsis
A41.81 Sepsis due to Enterococcus
A41.89 Other specified sepsis
A41.9 Sepsis, unspecified organism
A42.7 Actinomycotic sepsis
A46 Erysipelas
A48.1 Legionnaires' disease
A49.01 Methicillin susceptible Staphylococcus aureus infection, unspecified site
A49.02 Methicillin resistant Staphylococcus aureus infection, unspecified site
A49.3 Mycoplasma infection, unspecified site
A51.0 Primary genital syphilis
A51.1 Primary anal syphilis
A51.2 Primary syphilis of other sites
A51.44 Secondary syphilitic nephritis
A52.11 Tabes dorsalis
A52.12 Other cerebrospinal syphilis
A52.13 Late syphilitic meningitis
A52.14 Late syphilitic encephalitis
A52.15 Late syphilitic neuropathy
A52.16 Charcot's arthropathy (tabetic)
A52.19 Other symptomatic neurosyphilis
A52.3 Neurosyphilis, unspecified
A52.74 Syphilis of liver and other viscera
A52.75 Syphilis of kidney and ureter
A52.76 Other genitourinary symptomatic late syphilis
A54.00 Gonococcal infection of lower genitourinary tract, unspecified
A54.01 Gonococcal cystitis and urethritis, unspecified
A54.02 Gonococcal vulvovaginitis, unspecified
A54.03 Gonococcal cervicitis, unspecified
A54.09 Other gonococcal infection of lower genitourinary tract
A54.1 Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess
A54.21 Gonococcal infection of kidney and ureter
A54.22 Gonococcal prostatitis
A54.23 Gonococcal infection of other male genital organs
A54.24 Gonococcal female pelvic inflammatory disease
A54.29 Other gonococcal genitourinary infections
A54.30 Gonococcal infection of eye, unspecified
A54.31 Gonococcal conjunctivitis
A54.40 Gonococcal infection of musculoskeletal system, unspecified
A54.49 Gonococcal infection of other musculoskeletal tissue
A54.6 Gonococcal infection of anus and rectum
A54.86 Gonococcal sepsis
A54.89 Other gonococcal infections
A54.9 Gonococcal infection, unspecified
A55 Chlamydial lymphogranuloma (venereum)
A56.00 Chlamydial infection of lower genitourinary tract, unspecified
A56.01 Chlamydial cystitis and urethritis
A56.02 Chlamydial vulvovaginitis
A56.09 Other chlamydial infection of lower genitourinary tract
A56.11 Chlamydial female pelvic inflammatory disease
A56.19 Other chlamydial genitourinary infection
A56.2 Chlamydial infection of genitourinary tract, unspecified
A56.3 Chlamydial infection of anus and rectum
A56.8 Sexually transmitted chlamydial infection of other sites
A57 Chancroid
A59.00 Urogenital trichomoniasis, unspecified
A59.01 Trichomonal vulvovaginitis
A59.02 Trichomonal prostatitis
A59.03 Trichomonal cystitis and urethritis
A59.09 Other urogenital trichomoniasis
A59.8 Trichomoniasis of other sites
A59.9 Trichomoniasis, unspecified
A60.00 Herpesviral infection of urogenital system, unspecified
A60.01 Herpesviral infection of penis
A60.02 Herpesviral infection of other male genital organs
A60.03 Herpesviral cervicitis
A60.04 Herpesviral vulvovaginitis
A60.09 Herpesviral infection of other urogenital tract
A60.1 Herpesviral infection of perianal skin and rectum
A60.9 Anogenital herpesviral infection, unspecified
A63.0 Anogenital (venereal) warts
A63.8 Other specified predominantly sexually transmitted diseases
A64 Unspecified sexually transmitted disease
A66.0 Initial lesions of yaws
A66.2 Other early skin lesions of yaws
A66.3 Hyperkeratosis of yaws
A67.0 Primary lesions of pinta
A67.1 Intermediate lesions of pinta
A67.2 Late lesions of pinta
A67.3 Mixed lesions of pinta
A74.89 Other chlamydial diseases
A74.9 Chlamydial infection, unspecified
A79.82 Anaplasmosis [A. phagocytophilum]
A80.9 Acute poliomyelitis, unspecified
A92.39 West Nile virus infection with other complications
B00.1 Herpesviral vesicular dermatitis
B01.89 Other varicella complications
B01.9 Varicella without complication
B02.0 Zoster encephalitis
B02.1 Zoster meningitis
B02.21 Postherpetic geniculate ganglionitis
B02.22 Postherpetic trigeminal neuralgia
B02.23 Postherpetic polyneuropathy
B02.24 Postherpetic myelitis
B02.29 Other postherpetic nervous system involvement
B02.7 Disseminated zoster
B02.8 Zoster with other complications
B02.9 Zoster without complications
B03 Smallpox
B04 Monkeypox
B05.4 Measles with intestinal complications
B05.89 Other measles complications
B05.9 Measles without complication
B06.00 Rubella with neurological complication, unspecified
B06.09 Other neurological complications of rubella
B06.89 Other rubella complications
B06.9 Rubella without complication
B07.0 Plantar wart
B07.8 Other viral warts
B07.9 Viral wart, unspecified
B08.09 Other orthopoxvirus infections
B08.1 Molluscum contagiosum
B08.21 Exanthema subitum [sixth disease] due to human herpesvirus 6
B08.22 Exanthema subitum [sixth disease] due to human herpesvirus 7
B08.8 Other specified viral infections characterized by skin and mucous membrane lesions
B09 Unspecified viral infection characterized by skin and mucous membrane lesions
B10.89 Other human herpesvirus infection
B15.0 Hepatitis A with hepatic coma
B15.9 Hepatitis A without hepatic coma
B16.0 Acute hepatitis B with delta-agent with hepatic coma
B16.1 Acute hepatitis B with delta-agent without hepatic coma
B16.2 Acute hepatitis B without delta-agent with hepatic coma

Modifier Descriptors

Modifier	Description
CPT® Modifiers	
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
33	Preventive Services
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional

Modifier	Description
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
CPT® Category II Modifiers	
1P	Performance Measure Exclusion Modifier due to Medical Reasons
2P	Performance Measure Exclusion Modifier due to Patient Reasons
3P	Performance Measure Exclusion Modifier due to System Reasons
8P	Performance Measure Reporting Modifier - Action Not Performed, Reason Not Otherwise Specified
HCPCS Level II Modifiers	
A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	Dressing for nine or more wounds
AA	Anesthesia services performed personally by anesthesiologist

Modifier	Description
AB	Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
AE	Registered dietician
AF	Specialty physician
AG	Primary physician
AH	Clinical psychologist
AI	Principal physician of record
AJ	Clinical social worker
AK	Non participating physician
AM	Physician, team member service
AO	Alternate payment method declined by provider of service
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
AQ	Physician providing a service in an unlisted health professional shortage area (HPSA)
AR	Physician provider services in a physician scarcity area
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
AT	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with a surgical dressing
AX	Item furnished in conjunction with dialysis services
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD
AZ	Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
BA	Item furnished in conjunction with parenteral enteral nutrition (PEN) services
BL	Special acquisition of blood and blood products
BO	Orally administered nutrition, not by feeding tube
BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item
BU	The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
CB	Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable
CC	Procedure code change (use 'CC' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
CD	AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable
CE	AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity
CF	AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable
CG	Policy criteria applied
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CR	Catastrophe/disaster related
CS	Cost-sharing waived for specified COVID-19 testing-related services that result in and order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in rural health clinics and federally qualified health centers during the COVID-19 public health emergency

Terminology

Terminology	Explanation
Abdominal aorta	Largest artery supplying the abdominal cavity, part of the aorta and continuation of the descending aorta from the thorax; it divides farther into iliac arteries.
Abdominal ultrasound	This is a non-invasive technique which uses sound wave to take images of the intra-abdominal structures (i.e., liver, gallbladder, pancreas, bile ducts, spleen, and abdominal aorta).
Abdominal wall	May refer to muscle covering the abdomen, or to the skin, fascia, muscle, and membranes marking the boundaries of the abdominal cavity.
Abdominoperineal	Refers to the abdomen and the perineum, the area between the anus and genitals.
Aberrant renal vessel	A vessel of the kidney that is different from the norm anatomically.
Ablation	Removal of tissue, a body part, or an organ or destruction of its function.
Abscess	Sac or pocket formed due to the accumulation of purulent material, pus, in the soft tissue, caused by infection.
Adenomatoid tumor	Benign growth that generally presents in the genital tract, in regions such as the testis.
Adhesion	Fibrous bands that form between tissues and organs, sometimes as a result of injury during surgery; they may be thought of as internal scar tissue.
Adolescent	Teenager.
Adrenal	Refers to the adrenal glands, located at the top of each kidney, or their secretions.
Adrenal gland	A gland located on top of the kidney; produces hormones that are responsible for functions such as heart rate control and blood pressure; they also produce the stress hormone, commonly known as the flight or fight hormone, in addition to many more.
Algorithm	A specific set of step by step calculations using defined inputs at each step to produce a useful output; specifically for MAAAs, the output involves some sort of diagnostic or prognostic information about treatment options or disease outcomes.
Allograft	A tissue graft harvested from one person for another; donors include cadavers and living individuals related or unrelated to the recipient; also called allogeneic graft and homograft.
Allotransplantation	An organ or tissue transferred between genetically different individuals of the same species.
Amputation	Removal of a body extremity because of trauma or surgery; the surgical removal helps to control pain or a disease process in the affected limb.
Anastomosis	Connection between two structures, anatomical or surgically created, such as between two blood vessels or the colon after resection of a part; types of anastomoses include end to side and side to side.
Androgen	A hormone or compound, usually a steroid, that stimulates or controls male or female hormonal activity or production.
Androgen insensitivity syndrome	Medical condition affecting sexual development before birth; patients with this syndrome are genetically male.
Anesthesia	A medication induced state that reduces or eliminates sensitivity to pain, depending upon the type of anesthesia administered; general anesthesia renders the patient completely unconscious, while local or regional anesthesia reduce sensation to pain in specific areas of the body; spinal anesthesia involves the injection of anesthetic into the nerves of the spine, typically the lumbar spine, to reduce sensitivity to pain in the area of the body below the injection site.
Aneurysm	Weakness in the wall of a blood vessel, such as the aorta, or the wall of heart chamber, typically the left ventricle, causing the wall to balloon out; sometimes requiring surgical excision or repair to prevent rupture.
Angiography	A medical imaging technique in which the provider injects a dye into blood vessels and uses plain X-rays, computed tomography, or magnetic resonance imaging to visualize the inside, or lumen, of the vessels; more specific terms include arteriography when performed on the arteries or venography when performed on the veins; angiography can also be used to study blood supply to organs such as the heart, kidneys, and liver.
Angioplasty	A surgical procedure to widen a narrowed or blocked artery.
Anorectovaginoplasty	A surgical technique to repair female anorectal and vaginal defect or malformation.
Anterior	Closer to the front part of the body or a structure.

Terminology	Explanation
Antibiotic	Substance that inhibits infection.
Antibody	Also called immunoglobulin; a protein that the body produces in the blood as part of the immune response to neutralize specific invaders such as bacteria or viruses, but occasionally reacts to the patient's own body; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anticarcinogenic agent	Any agent that destroys growth and reproduction of cancer cells.
Anticoagulant	A drug that prevents clot formation within the blood vessels and dissolves any blood clot formed previously.
Antifungal agent	A drug used to eliminate or inhibit the growth of fungi.
Antigen	Foreign bodies, such as bacteria, that enter the human body, or substances that form within the body, that cause an immune response, such as antibody production, and possibly infection; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anti-reflux flap valves in Camey enterocystoplasty	The ureters are respectively joined to the two cut ends of the ileum; this suture site acts as a one way channel so that urine does not travel back to the kidneys.
Anus	External opening of the rectum where the gastrointestinal tract ends.
Aorta	The main artery that comes out of the top of the left ventricle and carries oxygenated blood to the body; it consists of an ascending and descending aorta which serve the upper and lower parts of the body respectively.
Aortic lymph nodes	Lymph nodes in the aortic area.
Appendix	A non-functional small tube like sac attached to the lower portion of the large intestine.
Arcus tendineus fascia pelvis (ATFP)	Also referred to as the white line, this is the attachment point for the pubocervical fascia to support the anterior walls of the vagina that have prolapsed; it is a thick band of the fascia over the obturator internus muscles running in an arching line from the pubis to the ischial spine.
Arterial access	Situated or occurring within an artery.
Arteries	Vessels that carry oxygen rich blood away from the heart to the rest of the body.
Arteriovenous anastomosis	An abnormal connection between an artery and a vein made either surgically, as a result of trauma or a medical condition, or congenital; also be referred to as an arteriovenous fistula or graft.
Arteriovenous fistulae	A provider surgically creates a direct connection between an artery and vein.
Arteriovenous graft	A provider surgically connects a vein to an artery using a soft plastic tube or an organic material from a person or animal.
Arteriovenous malformation	A mass of interwoven arteries and veins that interferes with blood flow; often congenital, or present at birth.
Artery	A blood vessel that carries oxygenated blood from the heart to different parts of the body.
Aspirate	Small amount of cells or fluid from a cyst or mass.
Aspiration	Removal of fluid, gas, or other material through a tube attached to a suction device, often combined with irrigation, the instillation of fluid to wash out a cavity such as the abdomen or stomach or to clean a wound; also withdrawal of material, often with a needle; can also refer to breathing in fluid or food material.
Atrial fibrillation	A heart rhythm disorder where the atrial appendage, a small pouch in the heart, does not squeeze rhythmically with the left atrium, causing blood inside the pouch to become stagnant and prone to produce blood clots.
Atrophy	Partial or complete washing away of a part of the body.
Autogenous tissue graft	Tissue a provider harvests from the patient's own body and uses to replace diseased, damaged, or missing tissue.
Autograft	Donor tissue or organ obtained from one part or area of the body and placed on a different body part or area of the same individual
Autotransplantation	The process of excision of organs or tissues and relocated it into a new location of the same individual.
Axilla	The armpit.
Backbench	A sterile environment in the operating room but separate from the operating table where a provider prepares grafts before transplantation.

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